Case No. MD-07-0374A

In the Matter of

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ALEXANDER VILLARES, M.D.

CONSENT AGREEMENT FOR

Holder of License No. 32704
For the Practice of Allopathic Medicine
In the State of Arizona

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Alexander Villares, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

- Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement").
 Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.
- 2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.
- This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.
- 4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.
- This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

 express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

- 6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.
- 7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.
- 8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.
- 9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.
- 10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

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11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

A.

ALEXANDER VILLARES, M.D.

DATED: 5/7/08

FINDINGS OF FACT

- The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- Respondent is the holder of license number 32704 for the practice of allopathic medicine in the State of Arizona.
- 3. The Board initiated case number MD-07-0374A after receiving notification from hospital that Respondent resigned from the medical staff due his care and treatment of a fifty-eight year-old female patient ("JD") and a sixty-two year-old male patient ("JS").

PATIENT JD

- 4. On March 6, 2007, JD was admitted by hospital staff with abdominal pain and vomiting. A surgical consultation was ordered with Respondent. Respondent made progress notes on March 7, 2007, March 8, 2007 and March 9, 2007, indicating he saw JD and examined her. Respondent's note on March 9, 2007 stated that an x-ray did not support small bowel obstruction. However, the computed tomography (CT) scan ordered by the hospitalist on March 8, 2007 revealed findings compatible with either an ileus or small bowel obstruction.
- 5. JD continued to complain of abdominal pain and was seen emergently by another surgeon who diagnosed her with small bowel obstruction. An emergency laparotomy was performed that revealed 4.5 feet of necrotic small intestine with perforation, severe hemorrhagic peritonitis and abscesses. JD recovered and was discharged on March 18, 2007.
- 6. During an investigational interview on September 13, 2007 with Board Staff, Respondent admitted that he never saw JD or examined her on March 7, 2007 even though he documented that he did in her medical record.

- 7. The standard of care requires a surgeon caring for a patient with small bowel obstruction to see the patient promptly, follow the patient closely and promptly document all the results of his follow up, including daily physical examination and reviewing all radiologic and laboratory data. If the patient fails to improve, the standard of care requires an exploration of the abdomen.
- 8. Respondent deviated from the standard of care because he did not promptly see JD even though he was consulted regarding her care for small bowel obstruction and he did not follow JD closely and promptly document all the results of his follow up, including daily physical examinations and reviewing all laboratory data. Respondent did not explore JD's abdomen following her complaints of continued pain.
- Respondent's failure to timely see and closely follow JD led to her small bowel obstruction progressing to infarction and perforation.

PATIENT JS

- 10. On February 2, 2007, JS presented to the emergency room (ER) and was admitted with abdominal pain, distension and obstipation. The ER physician's assessment was that JS had a bowel obstruction. According to the medical records, the ER physician noted in JS's chart that the case was discussed with Respondent at 12:33 p.m. Respondent did not see JS on that date. At 11:30 p.m., Respondent was contacted by the hospitalist after JS had multiple difficulties, including cardiac arrest and the inability of hospital staff to pass a nasogastric tube. Respondent did not present to see and evaluate JS.
- 11. On February 3, 2007 at 10:00 a.m., Respondent saw and evaluated JS. Subsequently, JS experienced multiple difficulties, went into cardiac arrest and died at 3:45 p.m.

- During an investigational interview with Board Staff, Respondent denied the consultation with the ER physician on February 2, 2007 regarding JS's condition. Respondent stated he was in the operating room all day and does not take calls while operating. Respondent maintained he was not aware of JS's diminished state until 11:30 p.m. on that date when contacted by the hospitalist. Respondent stated the hospitalist told him that JS was not a surgical candidate and indicated he did not need to see him that night.
- 13. The standard of care requires prompt evaluation by a surgeon of a patient with small bowel obstruction.
- 14. Respondent deviated from the standard of care because he did not promptly see and evaluate JS.
- 15. Although it is unlikely JS's outcome would have been different JS may have survived had he been promptly evaluated and treated by Respondent.

CONCLUSIONS OF LAW

- The Board possesses jurisdiction over the subject matter hereof and over Respondent.
- 2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. § 32-1401 (27)(t) ("[k]nowingly making any false statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a healthcare institution.").

<u>ORDER</u>

IT IS HEREBY ORDERED THAT:

- Respondent is issued a Letter of Reprimand for failure to timely see two patients with small bowel obstructions and for documenting a physical examination that he did not perform.
- Respondent is placed on probation for five years with the following terms and conditions:

A. Continuing Medical Education

Respondent shall within **one year** of the effective date of this Order obtain **20 hours** of Board Staff pre-approved Category I Continuing Medical Education (CME) in **ethics**. Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license. The probation shall terminate upon successful completion of the CME.

B. Chart Reviews

Board Staff or its agents shall conduct random chart reviews. Based upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action.

- C. Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.
- D. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in

1	the practice of medicine. Periods of temporary or permanent residence or practice outside
2	Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary
3	period.
4	This Order is the final disposition of case number MD-07-0374A.
5	DATED AND EFFECTIVE this day of, 2008.
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7	ARIZONA MEDICAL BOARD
8	(SEAL)
9	By Jubby
10	Lisa S. Wynn / Executive Director
11	ORIGINAL of the foregoing filed
12	this 2 day of 2008 with:
13	Arizona Medical Board 9545 E. Doubletree Ranch Road
14	Scottsdale, AZ 85258
15	EXECUTED COPY of the foregoing mailed this day of 2008 to:
16	Alexander Villares, M.D.
17	Address of Record
18	Min Banzo
19	Investigational Review
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